Reference is made to your presolicitation notice MDA906-02-R-0006 (Received 5 Aug 2002)

The notice states that the West Region contains certain Texas zip codes that are included in the catchment area of Cannon Air Force Base. The TMA Catchment Area Directory, located at http://www.tricare.osd.mil/, indicates that all of the Texas zip codes have been terminated from the Cannon Air Force Base catchment area. Please clarify.

RESPONSE: When Cannon AFB was an inpatient facility, there was a carve-out of 6 Texas zip codes within 40 miles of Cannon (79009, 79035, 79053, 79325, 79344, 79347) placing them in the Central Region. Cannon downsized April, 1999, and these zips were mistakenly transferred from the Cannon catchment DMIS 0085 (Region 7) to Texas state non-catchment 0993 (Region 6). However, those Texas zip codes were transferred back to the Central Region under New Mexico state non-catchment DMIS 0932, where they remain to the current time. The West Region under the new contract will continue this Texas carve-out.

2. In reference to the solicitation that was released on August 1, 2002, can you please tell me the following incumbent contractor information: (Received 2 Aug 2002)

Contractor(s):
Contract #:
Est. Value:
Award Date:
Exp. Date:
Contract Type:

RESPONSE: The contract type for current Managed Care Support contracts is firm fixed price for the administrative portion and fixed price redeterminable for health care.

Contract No.	Contractor	Award	Exp	Award
		Date	Date	Amount
MDA906-97-C-	Sierra Military Health Services,	30 Sep	31 May	\$1.3 Billion
0005	Inc.	97	03	
MDA906-97-C-	Humana Military Healthcare	12 Sep	30 Apr	\$3.2 Billion
0005	Services,Inc.	97	03	
MDA906-96-C-	Humana Military Healthcare	29 Sep	30 Jun	\$3.6 Billion
0002	Services,Inc.	95	03	
MDA906-95-C-	Health Net Federal Services, Inc.	28 Apr	31 Oct	\$1.8 Billion
0005		95	02	
MDA906-96-C-	TriWest Healthcare Alliance	27 Jun	31 Mar	\$2.3 Billion
0004		96	06	
MDA906-95-C-	Health Net Federal Services, Inc.	31 Aug	31 Mar	\$2.6 Billion
0007		95	03	
MDA906-94-C-	Health Net Federal Services, Inc.	8 Sep	29 Feb	\$493
0003		94	04	Million

3. I do a newsletter for Army retirees (Army Echoes). I would like to mention the contract release in the issue I'm getting ready to publish. When do the new contracts take effect? How will beneficiaries be notified that they have a new contractor. Will one contractor cover all TRICARE for Life beneficiaries (the dual fiscal intermediary contract)? How will a contract integrate all national retail pharmacy services? (Received 1 Aug 2002)

RESPONSE: On the TRICARE solicitation web site, Section B of the Managed Care Support (MCS) request for proposals (RFP) contains the schedule for each area of contract implementation. The unofficial chart below depicts the schedule in an easier format.

Regions	Current Regions	Start of Health Care Dates
North	Region 2/5	June 1, 2004
	Regions 1	September 1, 2004
South (plus foreign, CHCBP)	Region 6	November 1, 2004
	Regions 3/4	August 1, 2004
West	Region 11	April 1, 2004
	Regions 9/10/12 (Alaska)	July 1, 2004
	Region Central	October 1, 2004

When the new MCS contracts are implemented, the current seven MCS contracts covering 12 CONUS and 3 OCONUS regions will be consolidated into three contracts. The new contracts are designed to assist the direct-care system in coordinating health care delivery in the covered areas and ensure the optimal use of military treatment facility capacities. Beneficiaries will be advised of any change in contractor through briefings, press releases, and publications such as yours.

The Government does plan to award one contract to provide fiscal intermediary services for all TRICARE/Medicare dual-eligible beneficiaries (overseas beneficiaries are excluded). The draft statement of work for this proposed RFP is available on the TRICARE web site at http://www.tricare.osd.mil/pmo/t-nex/.

The Government intends to issue a separate contract for all retail pharmacy services. The retail pharmacy contract will integrate pharmacy services by providing links to each beneficiary's catastrophic cap and deductible files and the Defense Enrollment Eligibility Reporting System (DEERS) through the Department of Defense Pharmacy Data Transaction Service software. This single retail pharmacy contract, which will begin at the same time as the MCS contracts, also will eliminate problems in obtaining prescriptions while traveling, ensure that potential drug interactions are resolved consistently and reduce the Government's cost for drugs.

4. The contract in effect in 1996 when we returned from OCONUS included prevention programs and workshops--Stress Management, Couples Communication, Reunion Issues, etc--and a staff member available to develop and present programs tailored to our base population needs. As a professional working with military families in today's dangerous world, I wonder if this valuable service is being reinstated in the new contract? I believe if someone did a needs assessment of the military base service providers and users, they would find a high demand for this. (Received 1 Aug 2002)

RESPONSE: Services of the type you referenced will not be required in the Managed Care contracts, although an offeror could include these types of programs as a possible enhancement to their proposal. This does not mean that these services will not be available. Rather, the Department's leadership has determined that it is in everyone's best interest to allow MTF Commanders to determine which services should be provided with MTF resources and which should be purchased.

5. Are there any incumbents from other three previous existing contracts, if any? (Received 5 Aug 2002)

RESPONSE: Please refer to the TMA world wide web page at http://www.tricare.osd.mil for the current operating structure and the incumbent contractors. TRICARE currently has twelve regions which are supported by 7 managed care support contracts. Four companies currently hold these seven contracts. Further details are available through the web site – select either the TRICARE Map or the Links/References on the left side of the home page.

6. Is any portion of the RFP MDAS906-02-R-0006 available in electronic files? Do you have the zip codes of the eligible population so we can determine best provider match? Do you require certain mileage parameters to providers from home zip codes? (Received 6 Aug 2002)

RESPONSE: The entire RFP is electronic. It is available through the World Wide Web at http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS. Detailed data in support of this RFP, such as zip codes, may be purchased by following the instructions contained in the RFP Section L-12.f.(4)(b). We do have access standards for providers. These are contained in 32 C.F.R. 199.17 which is available on the TRICARE web site at http://www/tricare.osd.mil/ and using the pull down select MANUALS (TRICARE) The access standards are at 32 C.F.R. 199.17 (p)(5).

7. A copy of all Justifications and Approvals (J&As) and all Determinations and Findings (D&Fs) that have been approved for this RFP are requested. (Received 2 Aug 2002)

RESPONSE: The D&F is posted on the TRICARE MCS solicitation website.

8. What kind of changes, if any, are planned for the Uniformed Services Family Health Plan under the new managed care support services contracts? (Received 9 August 2002)

RESPONSE: The Uniformed Services Family Health Plan is separate and distinct from this solicitation. If and when a separate solicitation is issued, it will outline the program as well as the Government's requirements.

9. Subsection L.10.c. states: Offerors shall submit their anticipated organization structure fifteen calendar days prior to the submission of proposals. This document must include the prime contractor and major first tier subcontractors. The organization structure shall include addresses and telephone numbers. In the case of a joint venture or other business structure, a clear description of the organizational relationships must be disclosed.

We understand that Subsection L.10.c. requires pre-proposal submission of the offeror's anticipated organization structure, but the legal formation of that organization structure, including any required regulatory approvals, can be consummated at any time before award. Is this correct? (Received 9 August 2002)

RESPONSE: Yes

10. Subsection L.10.c. permits an offer to be submitted on behalf of a joint venture. We understand that this includes a "limited" or "contract" joint venture established solely for the purpose of performing the contract. Is this correct? (Received 9 August 2002)

RESPONSE: Yes

11. Subsection L.11.c states: The Government will award three contracts for managed care support services to three different sources under this solicitation. There will be one area per contract award. All prospective offerors may submit a proposal for any one or all three of the contract areas; however, no one offeror will be awarded more than one contract. For purposes of this solicitation, no offeror, its parent or subsidiary, or a company directly related to the offeror through common ownership, control or management by a parent company, (considered a "related entity" for purposes of this provision) may be awarded another contract if the offeror is awarded one contract under this solicitation. If an offeror is awarded a contract, a related entity may not in any manner underwrite health care under the award of another contract pursuant to this solicitation. If an offeror is awarded one contract, this restriction does not prohibit a related entity from acting as a subcontractor for the provisions of services (other than those involved in the underwriting of health care) under another contract award.

We understand that Subsection L.11.c applies to any offeror that is awarded a prime contract under the solicitation and such offeror's related entities, and it does not restrict a company that is not a prime contractor or related entity. Therefore, a company that is not a prime contractor or related entity could act as a subcontractor under more than one prime contract and in that capacity could underwrite health care in more than one area. Is this correct? (Received 9 August 2002)

RESPONSE: You are correct. Underwriting health care will no longer be a consideration as a prime or subcontractor. In a future amendment to the RFP, the Government intends to replace L.12.c with the following (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.):

"To foster an adequate number of viable contractors in order to reduce the risk to stability in administration of the TRICARE program and to ensure the continuous availability of health care services for TRICARE beneficiaries, the Government will conduct a full and open competition under this solicitation after the exclusion of sources. Therefore the Government will award three contracts for managed care support services to three different prime contractors under this solicitation. There will be one TRICARE Region (i.e., geographical area for contract performance) per contract award. Any offeror will be permitted to compete for one, two, or all three contracts; however, no prime contractor will be awarded more than one contract. The selection of three different prime contractors will occur even if a potential prime contractor submits the best proposal for each of the three contract Regions. If a potential prime contractor submits the best proposal for more than one contract

Region, the Government shall decide which one of the contracts to award to that prime contractor as determined to be in the best interests of the Government.

The Government will, subject to the limitations of FAR 9.604, recognize the integrity and validity of contractor team arrangements provided the arrangements are identified and company relationships are fully disclosed in an offer. For purposes of exclusion of sources under this solicitation, a company or business entity identified in an offer as a potential prime contractor shall be considered to include the named company or business entity, its parent or subsidiary, or a company or business entity directly related to the company or business entity through common (regardless of the percentage) ownership, control or management (whether by a parent company or otherwise). Under this solicitation, no company or business entity may be awarded more than one contract as a prime contractor. In addition, if a contract is awarded to a prime contractor in which a company or business entity has formed a business arrangement (e.g., partnership, joint venture, etc.) to act as a prime contractor, any offeror which includes that company or business entity in a business arrangement to act as a potential prime contractor shall be excluded from award of the other two contracts under this solicitation. A company or business entity, however, may be awarded a contract as a prime contractor in one TRICARE Region and team with a potential prime contractor as a subcontractor in either one or both of the other contracts awarded under this solicitation."

12. We understand that Subsection L.11.c. defines a "related entity" as the offeror, its parent or subsidiary, or a company directly related to the offeror through common ownership, control or management by a parent company. Therefore, a partnership, joint venture or consortium, which includes an offeror in one region, but which is not owned, controlled or managed by the offeror's parent is not a related entity for purposes of Subsection L.11.c. and could be awarded a prime contract in a different region area even if the offeror is awarded a prime contract in the first region under this solicitation. Is this correct? (Received 9 August 2002)

RESPONSE: In a future amendment to the RFP, the Government intends to replace the language contained in L.12.c with the replacement language provided in the response to question #11. (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.)

13. Subsection L.11.c permits a related entity to act as a subcontractor for the provision of services (other than those involved in the underwriting of health care) in a different region even if the offeror is awarded a prime contract under this solicitation. We understand that the services involved in underwriting health care are those described in Subsections H-1(a)&(b), and they do not include the activities specifically excluded in Subsection H-1(d). Therefore, a prime contractor or a related entity to a prime contractor in one region could act as a subcontractor in a different region and could engage in medical-management activities, such as case management, disease management, and utilization management, and administrative activities such as network development and maintenance, management of TSCs, billing and enrollment, non-claims customer service, contract administration and resource sharing under the subcontract. Likewise, the subcontract could include positive and negative incentives similar to those set forth in Sections H-8 & H-9, including performance guarantees and award fees relating to medical-management activities. Is this correct? (Received 9 August 2002)

RESPONSE: You are correct. In a future amendment to the RFP, the Government intends to replace the language contained in L.12.c with the replacement language provided in the response to question #11. (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.)

14. It sounds like the Resource Sharing program under the new contract will be a little different product from the current one. Can you clarify which party will be paying for this program (e.g. individual MTF)? Is this going to replace the Resource Support program? What will happen to the current Resource Sharing program/projects during transition period? (Received 9 August 2002)

RESPONSE: Resource Sharing, in concept remains the same. That being that when it is in the best interest of the Government and the MCSC, the MCSC will provide resources to augment the military treatment facilities capability. The MCSC will be reimbursed for all allowable costs associated with resource sharing per Section H-4.b. of the RFP. The MCSC may earn additional revenue as a result of these agreements based on the reduction in actual costs resulting from the civilian health care costs avoided by the resource sharing agreement. This program will replace the Resource Sharing financing mechanisms that exist in the current seven contracts. The existing Resource Sharing agreements will terminate with the expiration of the current MCSC contracts. There is no requirement for the successful offeror to negotiate new agreements to continue the services, but may do so if the parties determine if it is a win-win situation. The Government intends to review each existing Resource Sharing agreement to determine its value and if value exists, the Government will consider obtaining the services under a new resource sharing agreement, or through mechanisms outside of this solicitation. The Resource Support program will not continue under the resulting contracts of this RFP.

15. Please provide the most recent Service Contract Act (SCA) labor rates incorporated by contract modification for all regions other than the TRICARE Central Region. We do understand that SCA rates are not a requirement in this RFP. (Received 10 August 2002)

RESPONSE: This information must be requested, in writing, through the Freedom of Information Act process.

16. Does this solicitation contain any opportunities for facilities that provide Laser Vision Correction to subcontract to your contractors that win the bid? (Received 13 August 2002)

RESPONSE: There will be an opportunity to become a network provider of a potential bidder or bidders on the new Managed Care Support Contracts. The Government does not know at this time who those bidders will be but usually those companies contact potential interested providers who are not already in their commercial networks. However, based on the name of your company you might not be needed in a network as the TRICARE benefit does NOT cover laser surgery for corneal sculpting procedures to correct vision acuity.

17. According to attachment L-2 the zip codes for the new regions and the exclusions and inclusions are in Section J-4, Document XX, I can't seem to find Section J-4, Document XX anywhere. Can you point me to the right place to obtain these zip codes? (Received 14 August 2002)

RESPONSE: The zip codes are contained in the data tapes described in Attachment 8 listed in Section J. To obtain the data tapes, submit a written request (can be email) to the Contracting Officer. The reference to Section J-4, Document XX in Attachment L-2 has been corrected in amendment 0001 to the solicitation. Refer to Section F, paragraph F-4 for geographic area of coverage and Section L, paragraph L-12f(4)(b) for information regarding the data tapes.

- 18. Section G-3b. Contractor payments disbursed by the MTF Section (c) states, "The contractor may submit to the appropriate MTF a monthly consolidated invoice of passed (i.e. non-rejected) TED records. TMA reporting will provide the regular daily postings of data by DMIS ID and from these postings the appropriate MTF can check against the contractor invoice. The MTF can then approve the invoice for payment and forward to DFAS for payment." We have the following questions regarding this section: (Received 15 August 2002)
- a. The section states that the contractor "may" submit a monthly invoice to the MTF. Therefore, we assume that the contractor may submit invoices in a more frequent manner such as weekly as the MTFs will have access to the TEDs through TMA as they clear on a daily basis. This would also allow for a thorough review of the claims in a timely manner. Please confirm.

RESPONSE: The contractor may not submit invoices more frequently than month. The Section G-3 will be extensively revised in a future amendment and will clarify the process for submission of invoices.

b. We assume we would submit a periodic DD250 to the various MTFs which would be addressed to DFAS which they would they would forward to DFAS for payment. FAR 52.232-25 Prompt Payment would give the MTF 7 days to approve and send the invoice to DFAS. Please confirm that the MTF will operate under this section of the FAR.

RESPONSE: Revised 20 September 2002

Yes. Section G-3 will be revised in an amendment.

c. Under Section G-3a.(3)(I)[1] of the RFP regarding Underwritten Health Care Costs it states "Payment of underwritten healthcare health care cost claims will be made to the Contractor after the associated TEDs clear all edits. Payment Terms: Net 3 (following clearing all edits)". Section G-3.b. involves the payment through DFAS for the MTF enrollees going to the civilian sector. Since these costs are still underwritten can we assume that DFAS will pay the invoices on a net 3 basis? Please confirm.

RESPONSE: Section G-3 will be revised in an Amendment.

19. Section G-3b. Involves disbursements through the Defense Finance and Accounting Services (DFAS). (1) States that "This section covers civilian sector claims for both revised financing - MTF Prime enrollees and also Active Duty supplemental care." Chapter 19 Section 4 paragraph 2.0 of the August 2002 Operations Manual indicates that these ADSM costs will be

reimbursed to the contractor according to Chapter 3, Section 3 of the Operations Manual. Chapter 3 Section 3 involves payments by TMA through the submission of TEDs vouchers through the Federal Reserve Bank provisions. We assume that the Operations Manual would apply. Please confirm. (Received 15 August 2002)

RESPONSE: Your assumption is not correct. The language in the RFP Section G-3 will be revised to clarify the process.

20. The on-line manuals are not the ones referenced in MDA906-02-R-0006. Can you help me located the TOM, TPM, TRM, and TSM that are dated August 1, 2002? (Received 15 August 2002)

RESPONSE: We assume you have accessed the manuals that are in effect for the current Managed Care Support contract. Please access http://www.tricare.osd.mil/contracting/healthcare/solicitations/ and select the solicitation number MDA906-02-R-0006. Select Referenced Manuals. These are the manuals that will be used for this solicitation.

- 21. The following questions pertain to Section C of the solicitation (Received 15 August 2002)
- a. C-7.1.16 Does the requirement for *specialty providers* to provide the MTF with consultant reports within 5 days include behavioral health? If yes, what if the beneficiary refuses to provide consent?

RESPONSE: Yes, the provision applies to all types of care. However, if the beneficiary refused to release the information to their primary care provider, the specialty care provider must notify the primary care provider of this fact, in writing, within the established timelines.

b. C-7.5 - Will the mental health subcontractor be expected to convey UM decisions for MTF enrollees to the MTF commander if care is received outside the MTF (inpatient)?

RESPONSE: The Government is contracting with a single source, per region, to provide the services required in this RFP. As such, the provisions of this RFP will apply to the contractor with whom we eventually contract. If the "prime" contractor elects to subcontract a portion of the required work, the subcontractual relationship does not in any way alter the Government's requirements.

c. C-7.1.2 – Does this requirement that non-network MTF referrals are to be sent for Regional Director approval also pertain to mental health?

RESPONSE: Yes. Please see our previous response.

d. C-7.39 – Does this requirement apply to behavioral health? Clarify that the expectation is that the contractor will provide the clinical information to the MTF when referring a beneficiary into the MTF for treatment.

RESPONSE: Yes, the contract requirements apply to mental health care. The requirement is not to provide clinical information. Rather, the requirement is to

provide management information sufficient to allow the MTF Commander to promptly assess the workload leaving the MTF.

e. C-7.28 - Must the mental health subcontractor (1st tier) locate a senior executive with the authority to obligate the contractor's resources within a 15-minute drive of the Contracting Officer's office? Or is this requirement only for the Prime contractor?

RESPONSE: Again, we contract with a single entity. It is this entity that must locate a senior executive within 15 minutes of the Regional Director's office. This individual must be able to fulfill the contract requirements regardless of any subcontractual relationships the prime contractor may elect to employ.

f. C-7.28 - Where will the Regional Directors' offices be located for each region?

RESPONSE: Revised 9 September 2002

There will be three Regional Directors in CONUS. The planned locations are Washington, D.C.; San Antonio, Texas; and San Diego, California. Overseas is not relevant to this RFP.

g. C-2.1 (statement of objectives) - What services will be required by the contractors for active duty service members (example: utilization management, case management, referral services, both in the direct and indirect setting, exclusive of TPR and SHCP)?

RESPONSE: The requirements are specified in the RFP and the associated manuals.

h. C-7.3.3 – Will data from treatment at the MTF be available to the contractor in a timely manner to be included in required HEDIS measures?

RESPONSE: Revised 26 September 2002

The requirement to comply will HEDIS will be removed in a future amendment. Quality assurance performance measures will be monitored by the Government and reported to the contractor through the Lead Agent; see the amendment.

i. C-7.26 – Will the on-site Government representative be capable of clarifying on behalf of TMA or the MTF on TRICARE-related issues?

RESPONSE: The on-site person will NOT be a Contracting Officer and will have not authority to obligate the Government or direct the contractor to perform. The individual will serve as a contracting officer's representative; however, their authority will be limited based on the written delegation they receive from the Contracting Officer. The on-site individual will have the authority to monitor contractor performance.

22. How do I register for the presolicitation conference on the 28th? (Received 16 August 2002)

RESPONSE: There is a notice on the TRICARE website, http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS, regarding the pre-proposal conference. Instructions on how to register are posted in the notice.

23. RFP Section B, page 2 West Contract-Option Period I - The Option Period dates are shown as 1 April 2004 - 31 March 2004. Should the end date be 31 March 2005? (Received 16 August 2002)

RESPONSE: Yes

24. RFP Section B, 0103AB, page 2 indicates the paper claims rate is 9,550,442. Should the paper claim rate read 955,044 as indicated on Attachment L-8? (Received 16 August 2002)

RESPONSE: Yes. The paper claims rate was revised in Amendment 0001.

25. RFP Section B, page 2 West Contract – Option Period I - CLIN 0104AA states the "First 6 months contract period" as 15,415,560 PMPM. The PMPM appears to be calculated based on a full six months of estimated beneficiaries for all areas to be transitioned. As we understand Option Period I, the first six months will result in a phase-in beginning with Geographic Area 11 for 6 months, Geographic Area 9/10/12 for 3 months and Geographic Area Central does not begin until the start of the second 6 month period. Therefore, should the PMPM counts be calculated based on dates from start of healthcare, i.e. the dates stated above? Similar situations appear in the South and North contracts. (Received 16 August 2002)

RESPONSE: We are revising the estimated number of beneficiaries based on the phase-in of the regions. This revision will be posted in an upcoming amendment.

26. RFP Section B, CLIN 0103AA and 0103AB, page 2

This CLIN provides the estimated claim volume for electronic and paper claims. The data is also provided in Attachment L-8.

Based on Attachment L-8, the number of electronic claims is 85%, suggesting that either pharmacy or TFL claim volumes are part of these estimates. Is that correct or are these estimates based on the RFP requirement to have all provider claims submitted electronically? (Received 16 August 2002)

RESPONSE: Pharmacy and TFL claim volumes are not part of these estimates. Projections were based on several factors to include the effects of requiring all network providers to file electronically and the implementation of the Transaction and Code Sets requirements of HIPAA.

27. RFP Section B, page 3 West Contract, CLIN 0105AA Estimated cost = \$2,000,000 (Government provided estimate). It appears this estimate is based on a full year, whereas Option Period I is phased-in, such that all contract areas will not be operational for the full period. Does the Government still want the contractor to use the full \$2,000,000 for Option Period I? Similar situations appear in the South and North contracts. (Received 16 August 2002)

RESPONSE: Yes

28. RFP Section C-7.7 page 27, last sentence states: "The contractor's medical management program must fully support the services available within the MTF." Can the government please expand on this requirement? For example, will the MTFs make data available to the contractor to implement the contractor's medical

management programs? Are these issues the Government would expect the Contractor and MTFs to work through as part of the MOU? (Received 16 August 2002)

RESPONSE: Historical Direct Care data is contained in the Data Package, Section J, Attachment 8. In addition, it is expected that the contractor's medical management program model will be designed to optimize the MTF services following the requirements of the RFP and the program. The proposed program and its design are at each offeror's discretion.

29. RFP Section 7.9, page 27 - Please provide any workload volumes relative to the enrollment activities of TRICARE Plus? (Received 16 August 2002)

RESPONSE: TRICARE Plus Enrollment By Region – as of 20 Aug 02

Region Total Enrolled

Regit	JII	Total Lillon
HSR	01	27,404
HSR	02	7,206
HSR	03	15,083
HSR	04	9,521
HSR	05	9,323
HSR	06	19,218
HSR	07	3,381
HSR	80	7,009
HSR	09	8,347
HSR	10	4,246
HSR	11	8,473
HSR	12	2,783
HSR	13	8,281
HSR	14	1,712
HSR	15	1

Enrollments at the end of the Month for all regions:

35,916
62,277
84,014
100,270
115,165
119,217
123,413
127,102
128,548
131,216

30. RFP Section C-7.12.& C-&.15. pages 27 & 28, Will beneficiaries currently enrolled to a network PCM under the present contract be required to transfer enrollment to an MTF PCM if capacity exists at the start of the new contract or anytime during the term of the new contract? (Received 16 August 2002)

RESPONSE: revised 20 September 2002

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached.

31. RFP Section C-7.3.2., page 26, states "Ninety-six percent of referrals of MHS beneficiaries, residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual." The occurrence of Hospital-based providers not signing agreements with managed care organizations (MCO) is a chronic problem in the industry. It is obviously in the best interest of MCOs to negotiate rates, sign agreements, and have these providers become part of their network. Unfortunately, many of these providers never have and never will become network providers. TMA seems to recognize this problem because the quoted Section goes on to state, "The Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception." If it is understood that having these providers participate in the network is in the best interest of the MCO, and that TMA recognizes this as a sometimes insurmountable problem, why is this punitive requirement imposed on the contractor? Will the Government consider amending the RFP and establishing this standard at an achievable level? (Received 16 August 2002)

RESPONSE: The Government has recognized that in some areas of the country obtaining providers for the network is a challenge and has taken that into consideration by several factors: The requirement only applies in Prime service areas (MTF catchment areas and BRAC sites plus those of the contractor's choosing). The requirement applies to only 96% of the referrals and on an exceptional basis (e.g., nonavailability of a subspecialist in the network) the requirement may be waived.

32. RFP Section C-7.9., page 27, states, "The contractor shall meet with and establish a Memorandum of Understanding with the Marketing and Education Contractor in accordance with the TRICARE Operations Manual, Chapter 16, Section 1 specifying the frequency, type, and content of information the contractor shall provide the Marketing and Education contractor." There is no mention of this requirement in Chapter 16, Section 1 of the TRICARE Operations Manual 6010.51-M, August 1, 2002. Please clarify. (Received 16 August 2002)

RESPONSE Revised 12 November 2002

RESPONSE: The requirements for establishment of an MOU will change in a future manual change and will be addressed in the TOM Chapter 12, Section 1. Nov 1, 02

33. RFP Section C-7.39., page 32, states, "The contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral." Please specify the type of referral information expected. (Received 16 August 2002)

RESPONSE: The information shall include the name of the enrollee, date of referral, and the service for which the beneficiary is referred.

34. RFP Section C-7.42, page 33, states, "The contractor shall provide pharmaceuticals to beneficiaries in situations where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit."

Please identify the type and expected volume of pharmaceuticals that are not provided through retail pharmacies, the TRICARE Mail Order Pharmacy or from specialized pharmacies? (Received 16 August 2002)

RESPONSE: An example of a non-retail, non-mail order prescription would be an initial supply of drugs filled from a hospital pharmacy upon inpatient release. Another example would be solutions or medications provided during a home health agency visit. The Government does not separately identify these pharmaceuticals.

35. RFP Section C-7.1.1, page 24 states "The contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract. When this contract and the accrediting body both have standards for the same activity, the higher standard shall apply." The government mentions NCQA as the recognized organization for HEDIS, does the government recognize NCQA as the accrediting organization for the contractor's network? What accrediting organization does the Government accept as being "nationally recognized"? (Received 16 August 2002)

RESPONSE: Generally, some of the nationally-recognized accrediting networks by the industry are NCQA, URAC, and JCAHO. The Government is not directing that a specific accrediting organization be used for TRICARE.

36. RFP Section C-7.20.2., page 28 states "The contractor shall establish twenty-four hour, seven days a week, nationally accessible (to include Hawaii and Alaska) telephone service, without long distance charges, for all MHS beneficiaries seeking information and/or assistance with urgent or emergent care situations. This function shall be accomplished with live telephone personnel only." Please clarify if this is considered a Health Care Information Line (HCIL) or a beneficiary information line for general plan information which includes location of network providers? (Received 16 August 2002)

RESPONSE: It is not a HCIL triage line but will provide information that will assist beneficiaries in locating the nearest providers, preferably network, during an urgent situation.

37. RFP Section C-7.33, Page 31, states: "The contractor shall implement processes and procedures that ensure full compliance with the "Presidents Advisory"
The process and procedures contained in this report have not been enacted as of this date. Some of the procedures appear to be inconsistent with requirements of the RFP. Examples are access to specialist and the requirement for beneficiary survey for disclosure of health information. Please clarify the specific standards and process, if any, to be met. (Received 16 August 2002)

RESPONSE: For access to specialists, the commission stated "Access to Specialists. Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan." We do

not find this inconsistent with the RFP. We are unable to identify specific instances of inconsistencies; please provide. The requirement stands regardless of whether or not the report has been enacted.

38. RFP Section F.5 Page 37, RFP states: "All reports shall be submitted electronically in Microsoft 97 Excell....." Would the Government consider amending the solicitation to state "All reports shall be submitted electronically in Microsoft 97 Office Suite and in a secure manner to the Government unless otherwise specified. (Received 16 August 2002)

RESPONSE: The Government will revise the current language in paragraph F.5. via a future amendment.

39. RFP Section G-3.b. (1) (c), page 43

The RFP states: "The contractor may submit to the appropriate MTF a monthly consolidated invoice of passed (i.e. non-rejected) TED records...... "The MTF can then approve the invoice for payment and forward to DFAS for payment." Please provide additional information about the format and details for MTF acceptance of the contractors invoice?

Please explain the Governments payment terms for this invoice? Please explain the Governments process for resolution of invoice issues?

RESPONSE: An amendment to the RFP will clarify this provision.

40. RFP Section H-8.1, page 51 states "Standard: Not less than 96 percent of contractor referrals within a Prime service area shall be to a MTF or network provider with an appointment available within the access standards." The contractor will attempt to optimize the use of the MTF by referring contractor enrolled beneficiaries to the MTF, but it is beyond the control of the contractor, if the MTF fails to provide access to care within the standards. Please clarify any specification about this standard. (Received 16 August 2002)

RESPONSE: If the MTF cannot provide the appointment within the access standards, then the contractor is required to provide a referral to a provider who has an appointment within the access standards.

41. Attachment J-2, page 8, Section VI states "Retired beneficiaries enrolled in Medicare Part B may have their enrollment fees waived if they provide a copy of their Medicare card as proof of enrollment in Medicare Part B." Is a retired beneficiary who is enrolled in Medicare Part B required to enroll in TRICARE Prime to receive TRICARE For Life benefits? (Received 16 August 2002)

RESPONSE: No.

42. Attachment J-3, page 3, Section II, 1,d, lists one reason for filing a disenrollment form to be "Loss of Prime eligibility due to turning 65 years of age." Is it necessary for a Prime enrollee to fill out a disenrollment form upon turning 65 or is it the loss of Prime status automatic? (Received 16 August 2002)

RESPONSE: A beneficiary may fill out the disenrollment form (which is still in draft form) upon turning 65; however, this is unnecessary as NED will automatically remove an enrollee from Prime on DEERS and notify the contractor of the action.

43. RFP Attachment L-1, Page 2, first paragraph states the South Contract will accept and process claims from all Medicare eligibles that are residing overseas. Currently, WPS is the claims vendor for the overseas PRIME/Standard beneficiaries. Please clarify whether WPS is currently processing the Medicare overseas claims, and if so, as primary or secondary payer for the overseas operation? (Received 16 August 2002)

RESPONSE: HMHS is processing all claims received for overseas medical care rendered to beneficiaries who are eligible for Medicare. Generally, TRICARE is primary payer as no Medicare benefits are available overseas.

44. RFP Attachment L-1, page 3, last bullet point: Performing customer service activities for all beneficiaries in the Region, including those NOT eligible for TRICARE reimbursable benefits in the civilian network, but who have a need to know about their military health benefits and how to access services to which they are entitled. Please clarify what is meant by "those not eligible for TRICARE reimbursable benefits in the civilian network, but who have a need to know..." (Received 16 August 2002)

RESPONSE: The contractor is required to assist all MHS beneficiaries who request assistance in understanding their benefits (Section C-7.16). This includes those beneficiaries who may have MTF access but do not have TRICARE health care coverage outside of the MTF; e.g., parents, parents-in-law.

45. RFP Attachment L-1, page 3; attachment L-2. The Executive Summary (attachment L-1) refers to the contractor's responsibility to actively assist the Regional Director and MTF Commanders.

Attachment L-2 (Regional Descriptions) states "The following three contracts are for assisting the Lead Agents/MTF Commanders in coordinating health care deliver in the covered regions ..."

Will the government please explain the organization structure and how the Regional Director and Lead Agents will work with the contractor, or will the Regional Directors office replace the Lead Agents offices? (Received 16 August 2002)

RESPONSE: The final governance structure has not yet been determined. There will be three Regional Directors and the existing Lead Agents will continue to be a key part of the overall governance structure. The Regional Director will be primarily responsible for the contract oversight and execution. The Lead Agents will be responsible for supporting the business plan that provides for patient care services in their area of responsibility (AOR). The Lead Agent will be focused on utilization of the military direct care system but will continue to have a working relationship with the contractor in regard to the purchased care for the MTF's in their AOR.

46. RFP Attachment L-3, 5.3.2.3 states "The contractor will have the opportunity to provide written input to the Award Fee Board." Will the contractor have the opportunity to review the surveys and any comments prior to the Board meeting to develop any input they might have? (Received 16 August 2002)

RESPONSE: The ACO, as directed by the Award Fee Determining Official, will request input from the contractor. It is their discretion what input will be requested and what information will be shared.

47. RFP Section L.11.c, page 81 - The RFP states: "All prospective offerors may submit a proposal for any one or all three of the contract areas; however, no one

offer will be awarded more than one contract." If an offeror chooses to submit proposals for more than one contract areas, please explain: (Received 16 August 2002)

a. Does the offeror submit multiple Technical/Performance Standards and Past Performance Proposals and Oral Presentations materials, one for each contract area?

RESPONSE: Yes

b. Does the offeror receive Oral presentation time-slots for each contract area?

RESPONSE: Yes

c. A related question, please explain the Governments rational for limiting an offerors ability to assuming underwriting risk in only one contract region

RESPONSE: The D&F that will answer this question is posted on the solicitation website (http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS). Select "Questions and Answers"; then select "Answer to Question 7."

48. RFP Section L.12 c., page 82 - This RFP citation states: "The documents listedbelow are to be submitted as separate entities."

Oral Presentation Slides Technical Proposal Past Performance Information Financial Information Cost Proposal Subcontracting Plan

The next paragraph of RFP Section L.12.c, states: "The primary component of the technical proposal is the oral presentation. The technical proposal shall be separated into two sections; Section 1-oral presentation slides and Section 2-written documentation required by the RFP. ..."

Since the oral presentation slides are part of the Technical Proposal, how can it be "submitted as separate entities"? Can the Government please clarify the construct and submission requirements of the Proposal? Also, please confirm, reference RFP Section L.12.a, page 81, and RFP Section L.12 f. (1) (a), page 87. Does the Government expect to receive only a technical proposal, limited to proposed performance standards and oral presentation slides? Please elaborate if necessary. (Received 16 August 2002)

RESPONSE: The technical proposal consists of two separate entities (sections): the oral presentation slides and the written documentation required by Section L-12f.(1)(a). The written portion of the Technical proposal is limited to the referenced slides and the standards proposed by the offeror.

49. RFP Section L-12.e.(4), page 86, states "The offeror shall specifically state, the percentage of current primary care and specialty providers that will continue to be network providers following the start of health care delivery." Offerors cannot factually make this statement nor offer the best price to the government without electronic listings of providers in the current contractors' networks. Will these listings be made available to offerors? If so, when will this information be provided?

(Received 16 August 2002)

RESPONSE: revised 26 September 2002

RESPONSE: The provider directories will be provided.

50. RFP Section L.12 (g) (2) Health Care Prices, page 90

This RFP section states: "Offerors shall propose target health care underwriting fee amount for each option period. The target fees shall be proposed as both fixed dollar amounts and as percentages."

Since the Target Underwritten Health Care Costs are only proposed for Option Period I, please describe how the offeror should determine the dollar amounts for Option Periods II through V. (Received 16 August 2002)

RESPONSE: The Government will not prescribe how offerors should determine the dollar amounts for target health care underwriting fees for Option Periods II through V. The target underwriting fees should be estimated by whatever methodology the offeror chooses. Offerors are reminded that the target underwriting fees for Option Periods II through V will be considered part of the total evaluated price for contract award considerations. The Government expects the reasonableness of the fees to be based on price competition. See Ouestion & Answer # 454 for additional information.

51. RFP Section M.6.a., page 93, states "Proposals will be evaluated for supporting the optimization of the direct care system through collaborative, DoD directed efforts in areas of medical management, referral management, provider network management, beneficiary and provider education, beneficiary/customer services, data management and data sharing, and resource sharing." Medical Management is defined in the TRICARE Operations Manual 6010.51-M, August 1, 2002, Appendix A, as follows: "MEDICAL MANAGEMENT: Contemporary practices in areas such as network management, utilization management, case management, care coordination, disease management, and the various additional terms and models for managing the clinical and social needs of the beneficiary to achieve the short and long term cost-effectiveness of the MHS while achieving the highest level of satisfaction among MHS beneficiaries." Since the terms provider network management and referral management are part of the definition of medical management, it appears that these two terms are used unnecessarily and confusingly in the quoted paragraph of Section M. Please clarify. (Received 16 August 2002)

RESPONSE: We find nothing confusing about either the paragraph or the definition. The RFP Section defines what a proposal will be evaluated on. The definition of Medical Management provides <u>some</u> of the traditional practices associated with medical management.

52. RFP Section M.6.c., page 94 states "Proposals will also be evaluated based on the offeror's approaches for achieving the 50th percentile of the NCQA's HEDIS measures based on all reporting plans for TRICARE Prime enrollees who are the fiscal responsibility of the offeror during the first two option periods of the contract will be evaluated." Will Military Treatment Facilities (MTF) be held to the same HEDIS requirements for their enrollees under this contract?

If MTF are not held to this same standard, how will the government meet their goal of continuous health improvement of the TRICARE population? How will the government ensure a "fully integrated patient information system" based on

information about the total TRICARE beneficiary population? Today, NCQA HEDIS standards for TRICARE do not exist. Please clarify what NCQA HEDIS standard will be followed – Commercial, Medicare, or Medicaid? (Received 16 August 2002)

RESPONSE: revised 26 September 2002

RESPONSE: The requirement to meet HEDIS measures will be removed in a future amendment. The amendment will also announce quality assurance performance measures that targets both the MTF and civilian enrollees.

53. RFP Section M.4.a., page 92 states "Factor 1- Technical Approach (includes proposal risk)". Please elaborate and clarify as to what is meant by proposal risk? (Received 16 August 2002)

RESPONSE: Proposal risk relates to the identification and assessment of the risks associated with an offeror's proposed approaches to performing the requirements of the contract.

54. C.7.34. If the contractor has one of the current regions and is assuming another portion of that region, do you assume that the gaining contractor could forward the losing contractor's telephone number to its main toll-free number for an adequate period of time for the beneficiary to be educated properly? Please confirm. (Received 16 August 2002)

RESPONSE: No, the requirement is to transfer the rights to the number. The incoming contractor would then assume responsibility for operating the number. The contractor shall ensure that anyone accessing the number is responded to within the requirements.

55. Reference Section L.12.f(2): Please confirm that the information requested in (b) and (c), addressing the narrative on overall past performance, is to be presented separately from the information in (d) through (i), addressing account-specific information. (Received 16 August 2002)

RESPONSE: The information is to be submitted at the same time in a single past performance volume. The 25 page limit applied to the narrative required in Section L.12.f(2)(b) does not apply to the information submitted in response to L.12.f(2)(d)-(j).

56. Reference L.12.f(2)(b): Requests offeror to support "supporting documentation" as part of its narrative on past performance. Please confirm that supporting documentation will not count toward the 25-page limit. Similarly, L.12.f(2)(f) requests reports and findings on subcontractors from their government accounts; please confirm that these reports/findings will not count toward the page limit. (Received 16 August 2002)

RESPONSE: Supporting documentation was deleted in Amendment 0001. The report submission requirement is not in Section L.12.f(2)(f) but in Section L.12.f(2)(i). In any case, the page limit does not apply to the requirements in Section L.12.f(2)(f) and Section L.12.f(2)(i).

57. L.12.f.(2)(b), Page 87, What is required by the item "Relationship of the experience to the appropriate customer"? What information is the Government looking for? (Received 16 August 2002)

RESPONSE: If, for example, the offeror's narrative includes claims processing experience, the reference to claims processing experience must include the customer for whom the offeror provided the service.

58. Has the government intentionally excluded moving the TRICARE program to true coordination of benefits rules as was done for TRICARE for Life? (Received 16 August 2002)

RESPONSE: The RFP is designed to purchase contractor support to manage the Program as defined. Changing TRICARE policy is beyond the scope of this solicitation.

59. Section B - Claims quantities – In the Western Region, Option Period 1 has higher claims quantity than Option Year 2. This seems overstated as the Western Region Option Year 1 contract is only to process 9 months of claims for Regions 9/10/12 and 6 months for the Central Region. We understand that the volumes listed are for evaluation purposes only, but significant over or under estimating of volumes will not give the government a fair estimate of the actual total costs. The claims volume in Schedule B does not agree to Attachment L-8 of the RFP in Option Period 1. Please clarify. (Received 16 August 2002)

RESPONSE: Claims volume projections are being revised. The revised estimates, for evaluation purposes only, will be published in an upcoming amendment.

60. Section B and H - How many months of healthcare should be included in the OP1 target cost? For example, in the South Region, should 9 months of Regions 3/4, and 5 months of the Region 6 be included? If the answer to the above is yes, then for the evaluation of Target Underwritten Health Care Costs, will the costs be annualized for both Regions 3/4 as well as 6 to avoid an unfair competitive advantage between the Regions? (Received 16 August 2002)

RESPONSE: In accordance with the contract schedule, the following number of months of health care should be included in the offeror's target underwritten health care costs for Option Period I. These partial-year costs will NOT be annualized by the Government during evaluations. There is no possible "unfair competitive advantage" since the healthcare delivery period for a particular contract is the same for all offerors.

Area	Current Region	Start of Health Care delivery	Number of Months in Option Period I
North	2/5	June 1, 2004	10
	1	September 1, 2004	7

South	6	November 1, 2004	5
	3/4	August 1, 2004	8
West	11	April 1, 2004	12
	9/10/12	July 1, 2004	9
	Central	October 1, 2004	6

61. C-7.1 Are the network requirements for the Alaska Prime Service Area the same as they are for any other Prime area? (Received 16 August 2002)

RESPONSE REVISED 30 December 2002.

RESPONSE: No. Please see Amendment 5.

62. C-7.1.16. Please clarify the return of mental health reports. These could only be supplied if the beneficiary signed a document allowing their release. We would recommend that mental health be excluded from the requirements. Please address these privacy concerns. (Received 16 August 2002)

RESPONSE: revised 11 September 2002

We expect mental health providers to obtain the necessary release and provide the required report. However, if the beneficiary refused to release the information to their primary care provider, the specialty care provider must notify the primary care provider of this fact, in writing, within the established timelines.

63. C-7.1.16. Concerning urgent/emergent specialty consultations being telephoned or faxed within one-hour to the PCM. We assume that this would apply to network specialists only as we would have no way of monitoring or enforcing this with non-network providers. Also, we are concerned about privacy issues if faxes are sent to machines during non-working hours. How would HIPAA privacy standards be accomplished under these protocols? We would recommend within one working day as the standard for network providers. Please address. (Received 16 August 2002)

RESPONSE: revised 20 September 2002

Yes, the requirement specifically states "network specialty providers." We do not believe HIPAA is an issue since every provider's office must already meet the security test required by HIPAA. We have listened to industry and in a future amendment will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

64. C-7.14. Will the monthly enrollment allotments be transmitted in the HIPAA compliant 820 transaction? (Received 16 August 2002)

RESPONSE: Yes

65. C-7.16. This section states "The contractor shall have the ability to provide TSC services during periods when access to the TSC physical space is limited or

terminated due to weather, war, security, or MTF/Base Commander's decision." Will CHCS access for all MTFs within the Region be allowed to be setup at the contractor's central location in order to meet the TSC requirements which will include MTF assignment by name for enrollment into CHCS and also the receipt of electronic referrals? If not, please amend this requirement to state that the affected MTFs and TSCs would work jointly to provide workarounds for workload impacts due to the unavailability of CHCS to the contractor. (Received 16 August 2002)

RESPONSE: Amendment 0001 changed the manner in which PCM information reaches CHCS. We believe all other requirements can be fulfilled without direct access to CHCS.

66. C-7.21.2. This section refers to beneficiary satisfaction. Is the contractor permitted to query beneficiaries on customer service satisfaction, provided that the information is used for internal purposes and not disseminated publicly? (Received 16 August 2002)

RESPONSE: Yes, in accordance with the provisions of the TRICARE Operations Manual which require approval of surveys.

67. C-17.21.18. This section states, "Amounts paid in excess of the CHAMPUS Maximum Allowable Charge (CMAC), diagnostic related groups (DRG), or prevailing charge to non-network providers shall not be reported or used as health care costs for the purpose of the actual costs reported for health care fee determination under Section H." We assume that this provision is for the purpose of calculating the fixed fee set per year and not for the purposes of minimum and maximum fee calculations. We further assume that these costs are acceptable underwritten costs. Are these assumptions correct? If not, please clarify. (Received 16 August 2002)

RESPONSE: These assumptions are not correct. These costs will not be included in the underwritten amount since, in most cases, they result from network inadequacy.

68. Attachment L-2, Please provide the document referred to as Section J-4, Document XX. In addition, will this document include a description of what is considered the Prime Service Area for each MTF and BRAC site with their associated zip codes? In order to complete the cost proposal, this information is necessary. (Received 16 August 2002)

RESPONSE: The reference to Document XX was removed from the RFP by Amendment 0001. Amendment 0001 clarifies that TRICARE Prime is required in a 40-mile radius surrounding each MTF. Where this is not a "catchment" area, offeror's are required to develop the zip codes covered.

69. Section G(n) and Section H-4 – Resource Support - Resource support is not referred to in the RFP. We assume that this program will not continue under this RFP. Please confirm.

RESPONSE: You are correct, Resource Support will not continue as a component of future Managed Care Support Contracts.

70. Section G-5 - "The Government will unilaterally determine the number of MHS eligibles two times each option period under the Per Member Per Month contract line items, once for the first six month period and once for the seventh through the

twelfth month." Will there be an eligible adjustment done prior to the start of Option Year 1? (Received 16 August 2002)

RESPONSE: No

71. Section H-2. - Partial payments of underwriting fee. "During the performance of each option period, the Government will pay the contractor, on a monthly pro-rated basis, an amount up to 50% of the target fee." Section G(p)[1] indicates that partial underwriting fees will be paid in accordance with Section H. Does the contractor invoice for this monthly? If so, what are the payment terms? If not, does TMA automatically remit and what are the payment terms? (Received 16 August 2002)

RESPONSE: Yes, the contractor invoices for all payments. As stated in H-2, the contractor may do so on a monthly basis. This partial interim payment of the underwriting fee is considered a non-cost reimbursement item, so in accordance with G-3.a.(3)a., this payment is not subject to the Prompt Payment clause. Generally speaking, TMA attempts to make payments in 30 days, but this is not guaranteed.

72. Section I – We would like the Government to consider adding FAR 52.244-6 Subcontracts for Commercial Items and Commercial Components to Section I. This would ease the flow down requirements placed on commercial businesses used for the purchasing of commercial items in the daily business of the contractor. (Received 16 August 2002)

RESPONSE Revised 30 December 2002

RESPONSE: The clause was added with Amendment 0007. See response to #1175.

73. Section L.12.f.(4) - Page 89 indicates: Offerors shall propose a firm-fixed-price for each option period for the Operation of TRICARE Service Centers (TSCs). This price will include all costs uniquely associated with the on-site operation of all TSCs for the contract region and any satellite TSCs established off post due to inadequate space on post. Specifically, the price will only include the cost of staff, equipment, and services required to accomplish those functions required in the TRICARE Operations Manual, Chapter 12, Section 3." We assume that the following of the contractors Disclosure Statement and Cost Accounting Standards by pricing this out with direct labor, other direct costs, overhead, general and administrative costs, and profit would be an appropriate costing methodology as required in Section K of this RFP. Please confirm. (Received 16 August 2002)

RESPONSE: The assumption is correct. Fully burdened costs consistent with the offeror's disclosed accounting practices should be proposed along with the applicable profit to calculate the total price for the TSC operation. This would include any indirect costs, general & administrative costs, facilities capital cost of money, etc.

74. Reference H-1 b (4)(b). Please verify that in amount (1), the target fee remains a positive number, and only the second part of the amount (20% of the difference between the target cost and the actual cost) is negative. Also, please verify that "greater of" does not mean the larger absolute value. (Received 16 August 2002)

RESPONSE: The questioner is correct in each case. In the amount (1) cited, the target fee is a positive number, the 20% contractor share in the second part of the amount is negative, and the "greater of" does not mean the larger absolute value.

75. Reference H-1 b (2)(b&c). These two sections appear to conflict regarding the setting of the retroactive target cost. In (b), it is said that the new target will be based on the prior year's target cost, while in (c), it appears that the new target is based upon actual healthcare costs from the prior year. Please clarify. (Received 16 August 2002)

RESPONSE: Sub-paragraph (b) describes the "estimated target cost" that will be used for purposes of exercising the option period, in the event the target cost is not negotiated by 30 days before the option period. In this case, however, this "estimated target cost" is only an interim value for purposes of exercising the option period. Then, this interim value will be replaced after the new option period is completed, using the retroactive formula described in sub-paragraph (c). The retroactive formula sets the target cost as the product of the actual underwritten CHAMPUS health care costs in the region in the previous option period (e.g., to set the OP 3 target the previous year would mean the actual costs in OP 2) trended by the national percentage change in underwritten CHAMPUS health care costs from the previous option period to the current option period (e.g., to set the OP 3 target, the trend would be the percentage change in national underwritten CHAMPUS costs from OP 2 to OP 3). Thus, it is this retroactive formula which ultimately sets the target cost in the event negotiations do not achieve an agreed upon target cost before the option period is exercised. Below is an example of the fall-back formula approach.

Hypothetical Example of Retroactive Calculation of

Target Healthcare Cost for OP 3,

if Prospective Negotiation Fails to Produce an Agreed-Upon Target

Actual Regional Cost in OP 2	Actual National CHAMPUS Cost for Underwritten Care		Target Cost in Region for OP 3	
	OP 2	OP 3	% Trend	
\$1,000M	\$3,200 M	\$3,520 M	10%	\$1,000M x 1.1 = \$1,100M

76. Reference H-1 b (2)(c). Please give the mathematical derivation of the "national trend factor for underwritten CHAMPUS healthcare costs." (Received 16 August 2002)

RESPONSE: Assume, for example, that the retroactive formula is being used to set the target cost retroactively for OP 3 of the West contract, and that OP 3 of the West contract covers April 2006 – March 2007. The national trend factor would be equal to the actual underwritten CHAMPUS costs in all three contract regions for April 2006 – March 2007 divided by the actual underwritten CHAMPUS costs in all three contract regions for April 2005 – March 2006. The actual underwritten CHAMPUS costs are defined as in Section H (e.g., measured from accepted TEDs, less unallowable costs determined by audits, estimated to completion, including resource sharing costs,

- etc.). Thus, on an incurred basis, if the actual national underwritten CHAMPUS costs were hypothetically \$3.52 billion for April 2006 March 2007, and the actual national costs incurred for April 2005 March 2006 1 were hypothetically \$3.20 billion, then the national trend factor for setting the West contract's OP 3 target if the formula were triggered would be 1.10 (3.52 / 3.20).
- 77. Reference H-1 b (2), second occurrence. If the target cost is set retroactively, how is the target underwriting fee set? Does the answer vary before and after the retroactive value is calculated?

RESPONSE: If the target cost is set retroactively, the target underwriting fee defaults to the fixed dollar value initially proposed for that option period in Section B (i.e., the dollar amount established at contract award, except as modified for definitized health care change orders or other equitable adjustments). This value will be used as the target fee both before and after the retroactive formula result is calculated. To summarize, the target underwriting fee is a fixed dollar amount.

78. Section H - Are all resource sharing expenditures, including projects where the providers/staff are paid on an hourly basis included in the cost reports and HCSR data tapes? If not, please provide expenditures by MTF? (Received 16 August 2002)

RESPONSE: The government does not believe that the data tapes and cost reports contain all information related to hourly paid Resource Sharing Staff. The available data was provided in Amendment 2.

79. August 2002 Operations Manual – Chapter 15 Section 3, paragraph 8.0 - Resource Sharing – One of the reporting requirements in this paragraph states "The number of outpatient visits and/or admissions "credited" to each agreement to meet the annual adjustment requirements." Please indicate what the annual adjustment requirements are as we don't believe there is a Bid Price Adjustment in the RFP. (Received 16 August 2002)

RESPONSE: Disregard the referenced provision; it will be deleted at a future date.

80. Please describe how the written proposal submission of Performance Standards will be evaluated. (Received 16 August 2002)

RESPONSE: Performance standards represent the product the offer is selling to the Government. We will evaluate the product as part of the technical evaluation of the offeror's ability to deliver the contract objectives and the proposal risk associated with the offer.

81. C.7.21.15 - Currently each region processes their own CHCBP claims. The assumption is being made that this will end and that any claims received in another region will be transferred to the holder of the South Region contract. Is that correct? (Received 16 August 2002)

RESPONSE: Yes

82. General – Please provide the enrollment revenue received for the latest three years by Region. Please list the dates the information applies to. (Received 19 August 2002)

RESPONSE: This response was revised on 12/9/02

Enrollment fee revenue (unaudited) for the latest full three years by current regions, as reported by the contractors for bid price agreement purposes, are provided in the table below. Potential offerors who have obtained historical data tapes are reminded that enrollment fees under the current contracts can be determined from these historical data tapes. Enrollment fee revenues derived from the data tapes may vary depending on method of data extraction, and adjustments made by the current contractors.

Enrollment Fee Revenue Reported by Contractor for BPA Purposes

Region	Option Period	Date	Enrollment Fee Revenue
1	OPT 3	6/00-5/01	\$11,324,011
	OPT 2	6/99-5/00	\$11,226,262
	OPT 1	6/98-5/99	\$6,710,265
2/5	OPT 3	5/00-4/01	\$17,805,779
	OPT 2	5/99-4/00	\$15,245,260
	OPT 1	5/98-4/99	\$11,952,315
3/4	OPT 5	7/00-6/01	\$34,044,719
	OPT 4	7/99-6/00	\$33,028,000
	OPT 3	7/98-6/99	\$29,923,379
6	OPT 6	11/00-10/01	\$24,292,121
	OPT 5	11/99-10/00	\$22,443,285
	OPT 4	11/98-10/99	\$20,268,309
7/8	OPT 5	4/01-3/02	\$24,632,066
	OPT 4	4/00-3/01	\$22,727,704
	OPT 3	4/99-3/00	\$21,234,983
9/10/12	OPT 6	4/01-3/02	\$18,981,859
	OPT 5	4/00-3/01	\$19,668,795
	OPT 4	4/99-3/00	\$18,821,552
11	OPT 7	3/01-2/02	\$9,128,374
	OPT 6	3/00-2/01	\$8,485,678
	OPT 5	3/99-2/00	\$7,805,568

83. Section L-14 Resource Sharing – This section states "The expected administrative costs of resource sharing shall be included by the offeror in preparing its administrative price." We assume that these administrative costs would include the cost of performing the financial analysis worksheets and the cost of performing the resource sharing reporting as required in the Operations Manual and not the subcontractor administrative costs associated with the administration of projects such as management, recruiting, credentialing, claims generation, administrative

support, etc. These costs are normally factored in as costs with each project as is the case with any commercial products. Additionally, Prime contractors may contract with different subcontractors on a project by project basis. Please clarify. (Received 19 August 2002)

RESPONSE: You are correct. Allowable administrative costs associated with each agreement shall be included in the agreement and not the overall fixed administrative price.

84. General - Currently, resource sharing providers are reimbursed under various methods. These methods include both those amounts billed on a HCFA 1500 and certain projects that are billed and paid on an hourly/salary basis. First, which of these costs are included in the data tapes supplied by the government?

RESPONSE: The data tapes include all costs for which a HCSR was submitted, including encounter records.

a. Second, if these costs continue, are they included as part of underwritten health care costs? If so, how will these be reported?

RESPONSE: Please see the RFP, Section H-4 for the requirements concerning underwritten health care costs and resource sharing.

b. Under the hourly project will a TED be produced? If so how? If not, how will the contractor be reimbursed? (Received 19 August 2002)

RESPONSE: If there is an hourly or monthly Resource Sharing project, payment and invoice process will be specified in the individual agreement. This is stated in the forthcoming amendment to Section G. If such a project involves professional services which can be reported using a CPT code, such workload may be captured through a TED. That also will be specified in the individual Resource Sharing agreement.

- 85. Section H-5d. This section states: "In reference to FAR 52.216-7(g), "audits", as used in this clause, includes audits on statistically valid samples. The audit results will be applied to the entire universe from which the sample was drawn to determine total unallowable costs. Overpayments made by the contractor, whether found in an audited sample or audit results applied to the entire universe from which the sample was drawn, are unallowable costs. The Contracting Officer will notify the contractor of intent to disallow costs in accordance with FAR52.242.1, Notice of Intent to Disallow Costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments." We have the following questions on this paragraph: (Received 19 August 2002)
- a. What is the rationale for not offsetting overpayments with underpayments?

RESPONSE Revised 16 December 2002

RESPONSE: It is the governments' goal to have all claims paid absolutely correctly. The government believes there are already adequate safeguards in place to ensure underpayments do not occur (i.e. beneficiary and provider complaints), therefore they are not included. The government must be assured that its' contractor is taking appropriate measures to prevent overpayments. In addition, the government does

not want the contractor to have any incentive that might cause the rebuttal of preliminary audit results to be slanted in any way. The goal is to pay the correct amount every time, not on average. Also, H-5 addresses FAR 52.216-7, Allowable Cost and Payment, which is a required clause for cost-reimbursable contracts. As with all cost-reimbursement contracts, the Government simply cannot reimburse a contractor for any unallowable costs (overpayments). Underpayments by a contractor simply cannot be reimbursed as it is not an incurred cost.

b. Please provide an example of how TMA will calculate the amount of costs to disallow if, for example, overpayments are found to be 2% during an audit.

RESPONSE: The costs to be disallowed would be from costs from which the sample was selected. For example, 2% of reported healthcare costs would be disallowed before comparison against target cost. If the total reported health care costs on TED records were, for example, \$100 million, a 2% overpayment error would result in \$2 million being disallowed. The remaining \$98 million would be compared against the target cost and used in determination of the fee earned.

c. Please also include how these disallowed costs will be applied against the contractor. Will the disallowed costs not be used in calculating the target fee or will they be offset against health care CLINs or administrative CLINs or will a lump sum payment from the contractor be expected?

RESPONSE Revised 16 December 2002

RESPONSE: All erroneous claims in the sample would have to be corrected and resubmitted (over payments). The disallowed costs will not be included in the allowable costs used in calculating the target fee. The extrapolated amount due will be collected from the contractor as a deduction from the healthcare CLIN payments. In no case shall the government pay any additional health care costs even if there is a net underpayment.

d. How often will these audits and calculations be performed? Please clarify. (Received 19 August 2002)

RESPONSE: Audits shall be conducted annually.

- 86. Section L.12.f.(2) Page 89 indicates, "The Government has established an estimated level-of-effort for case management/disease management for each option period provided in Section B. The Contract Line Items (CLINS) associated with this effort are cost-reimbursable. The Government estimate includes the cost of medical management programs meeting the criteria specified in Section C-5.2.7. Offerors shall propose a fixed fee for each of the five options periods. The fee shall remain fixed regardless of the levels of expenditures experienced by the contractor for this effort and shall not exceed ten percent (10%) of the estimated contract cost for this CLIN in accordance with regulatory guidance." We have the following questions on this paragraph: (Received 19 August 2002)
- a. Is the contractor free to input any unit price and amount on the 0x03AA CLIN series in Schedule B and not limited to the governments estimate?

RESPONSE: No. Offerors may not input any unit price and amount other than the Government provided estimate for the case management/disease management CLINS.

b. We assume that the estimated cost 0x03AA CLIN series would include direct costs plus the applicable overhead, G&A, and profit to match the requirements of Section K of the RFP and also to mirror the methodology in which the CLIN will be invoiced by the contractor. Please confirm.

RESPONSE: No. Offerors may not develop their own estimate. See answer to a. above.

c. Is the contractor prohibited from invoicing amounts over the contractor's estimated costs bid after the contract award is made?

RESPONSE: No. The Case Management/Disease Management CLINs are cost reimbursement. Section C details the requirements for proposing medical management programs for review and approval; to include individual program cost estimates. See the FAR and DFARS regarding administration of cost reimbursement contracts.

d. Is the fixed fee that can be bid limited to 10% of the contractor's price bid on the 0x03AA CLIN series or is it limited to 10% of the government's estimated cost contained in Schedule B?

RESPONSE: Offerors may not propose a fixed fee amount that exceeds 10% of the Government's estimated cost contained in Section B. Any amount proposed in excess of the 10% will be considered unreasonable and unallowable. See a. and b. above.

87. Section C-7.22 requires an Explanation of Benefit (EOBs) that describes the action taken on each claim be provided to each beneficiary and non-network provider. With consideration of the requirement in C-7.21.4 to provide an Internet Base Claims Processing System, is it acceptable to provide electronic EOBs in lieu of paper EOBs to beneficiaries and providers who prefer an electronic method of notification? (Received 20 August 2002)

RESPONSE: response revised 3 September 2002

Offerors may propose any method of fulfilling the requirement. All EOBs submitted to providers must be data compliant with the Transaction and Code Set Rule of HIPAA.

88. Your response to Question #17, which asks for the zip codes for the new regions as referenced as included in Section J-4, Document XX of the RFP directs the reader to L-12f(4)(b). This section requires a payment of \$3,000 for this information. Is there a way to obtain these zip codes at no charge since the zip codes for the new regions do not appear to align exactly with the old regions? (Received 20 August 2002)

RESPONSE: No, this information is only available as specified. However, the new regions combine existing regions without boundary changes.

89. CLINs 0001, 0002, 0003, 0101, 0102, 0601, 0602, 0603, 0604, 1101, 1102, 1103 and 1104 each require pricing for phase-in activities associated with a specific period of time for a geographic portion of the each new contract. Section F.5 (page 37 – 39) describes several start-up related deliverables and performance requirements to be completed relative to the date of Contract Award rather than the date associated with the start of transition for each geographic area. Please clarify how the offeror is to propose costs for activities associated with fulfilling the requirements specified in Section F.5 that precede the date parameters associated with CLINs 0001, 0002, 0003, 0101, 0102, 0601, 0602, 0603, 0604, 1101, 1102, 1103 and 1104.

RESPONSE: The effort associated with the deliverable items in Section F.5 should be priced in the applicable CLINs in accordance with the delivery schedule. For an item scheduled to be delivered during the phase-in period, the costs should be reflected in the price for that CLIN. For an item scheduled to be delivered during Option Period I, the costs should be reflected in the applicable transition-in CLIN price.

90. CLINs 0108, 0206, 0306, 0406, 0506, 0611, 0707, 0807, 0907, 1007, 1110, 1206, 1306, 1406 and 1506 each require pricing for transition-out activities. Section L.12.(4)(i)(6) (page 90) states "Offerors shall propose a firm-fixed-price for each option period for transition-out activities. This price will include all costs associated with transitioning to a follow-on contract." Section F.5(d) (pages 39 - 40) presents several transition-out related deliverables and performance requirements to be completed relative to the date of successor contract award or start of health care delivery. The solicitation neglects to specify the amount of time between successor contract award and the start of health care delivery. Please clarify the assumptions the offeror is to use for pricing activities that occur between successor contract award and the start of health care delivery.

RESPONSE: The offeror shall assume a minimum of 9 months transition between award of the successor contract and the start of health care of that contract. Transitional activities of the outgoing contractor are pre- and post-start of health care delivery of the successor contract as defined in the TOM Chapter 1.

91. RFP Section C-7.1.16 page 26, Second sentence of the section states: "In urgent/emergent situations, a preliminary report of a specialty consultations shall be conveyed to the beneficiary's primary care manager within one hour by telephone, fax, or other means with a formal written report provided within the standard." Considering that many, if not most, urgent/emergent situations occur during non-provider office hours, will the government consider restating this requirement to a 24 hour period? Please provide your rationale for the one hour preliminary report requirement.

RESPONSE: revised 20 September 2002

Please see the future amendments. We have listened to industry and in an amendment we will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

92. RFP Section C-7.21.18 page 30 - Last sentence states "CHAMPUS Maximum Allowable Cost". Should this state "CHAMPUS Maximum Allowable Charge"?

RESPONSE: Yes; revised in Amendment 0001

93. Section L-10.c, page 80 states "Offerors shall submit their anticipated organization structure fifteen calendar days prior to the submission of their proposals. This document must include the prime contractor and major first tier subcontractors. The organization structure shall include addresses and telephone numbers." This requirement is not among the documents listed in L.12.c, page 82. Should offerors submit their anticipated organization structure 15 days prior to submission on a CD-ROM? What level or organization detail is required for the offeror's and proposed subcontractor organizations?

RESPONSE: A Word document attached to an email to the Contracting Officer listing the prime contractor and major first tier subcontractors to include the addresses and telephone numbers each is sufficient.

94. RFP Section L-12.f (2) Past Performance Information, page 87: Subsection (b) states: The Government will only consider experience gained within the last three years" We assume that, for the purposes of Past Performance Information, this statement refers to information dating back to 10/1/99 which is a date 3 years prior to the schedule for submission of the Past Performance volume. Is this correct?

RESPONSE: An amendment will further clarify that the last 3 years is as of 60 days prior to the proposal submission date.

a. Subsection (b) states: "The information submitted shall include the following, at a minimum" "supporting documentation". We assume that this information **is not** included in the 25 page count. Is this correct? We assume that this information can include reports. Is this correct?

RESPONSE: The requirement to submit the supporting documentation with the narrative in Section L-12f.(2)(b) was removed in amendment 0001.

b. Subsection (d) states: "The offeror shall provide a brief discussion..."
We assume that this discussion **is not** included in the page count since these accounts may not be those referenced in the narrative. Is this correct?
Is there an associated page limit assumption that scope of work, successes and challenges need to be discussed? Please clarify the RFP Past Performance submittal requirements.

RESPONSE: Section L-12f(2)(d) brief discussion is not included in the page count. While there is no page limit, the operative word is "brief" and must not be a marketing or a sales presentation but should be factual.

c. Subsection (g)page 88, This section refers to "Attachment L-4". We assume the government meant Attachment L-5. Is this correct? Also in Subsection (g), This section refers to "...within the 36 months preceding the submission of the proposal." We assume that, for the Purposes of Past Performance Information, this is back to 10/1/99. This is correct?

RESPONSE: The reference should be Attachment L-5. This will be corrected.

d. Subsection (h) page 88, We assume the government intended to reference Attachment L-6 here. Is this correct? We assume key personnel information is excluded from the 25 page count. Is this correct?

RESPONSE: Key personnel information shall be submitted according to the format of Attachment L-6. This information is excluded from the 25 page count.

e. Subsection (i) page 88 states "The offeror shall provide copies of final reports and/or findings issued to any subcontractor....". We assume, given Section M indications, that the government intended this to include the prime contractor and subcontractors. Is this correct? We assume that, given the copies of the findings and the explanation required, that this information **is not** included in the 25 page limit? Is this correct? We assume that, for the purposes of Past Performance Information, that "two years prior to the submission" means findings issued back to 10/1/00. Is this correct?

RESPONSE: Include both prime and subcontractor reports which are is excluded from the 25 page limit. The complete phrase is "two years prior to the submission of the past performance information" with which the proposal submission date of November 1, 2002, would be reports issued two years prior to October 2, 2002.

95. Section L-12.f. page 87, Please confirm that the SF 33 does not need to be submitted with the Past Performance information.

RESPONSE: Paragraph L.12.f.(2)(a) does not mention the Standard Form 33. The paragraph pertains only to past performance information.

96. Section L.12.page 89 paragraph (2), immediately following paragraph L.12.f(4)i, (paragraph numbering sequence appears inconsistent) addresses the estimated level of effort for case management. RFP states: "The Government estimate includes the cost of medical management programs meeting the criteria specified in Section C-5.2.7" There is no section C-5.2.7 in the RFP.

RESPONSE: The reference in Section L should be C-7.7. Section L will be revised in a future amendment.

a. What then is the definition of Case Management/Disease Management and what are the criteria for what must be included in CLIN 0105?

The definition of case management is in the TOM, Appendix A; for disease management, see the definition of medical management in the TOM, Appendix A.

97. There appears to be a discrepancy between directives in the Operations Manual and Policy Manuals released August 2002. The issue concerns requirements for preauthorization of outpatient mental health services and could be significant when determining operational requirements in the technical proposal. Policy Manual-Chapter 7, Section 3.13-IIC-pg1-states the contractor shall pre-authorize all outpatient psychotherapy beyond the eight visit in an enrollment period. (This has been the instruction that mental health has operated under the current contract period).

Operations Manual – Chapter 7, Section 2.0 and 2.0-Preauthorizations-pg 1 The required outpatient services will be pre-authorized: Adjunctive Dental- is the only service listed.

Outpatient mental health is not listed under this category. The only place mental health services are listed as requiring preauthorization is under inpatient admissions. Will the Government please clarify?

RESPONSE: The discrepancy will be corrected in an amendment. The requirement to preauthorize outpatient mental health care will be deleted.

- 98. TRICARE Operations Manual; Chapter 15, Section 3, 14.0, page 8, requires a monthly report to the Regional Office and the Contracting Officer on Customer Satisfaction. "The Customer Satisfaction Report shall include:
- The contractor's measurement of satisfaction, by category, to include active duty personnel, dependents of active duty, retirees and other eligible beneficiaries under age 65;
- Network providers;
- Non-network providers;
- MTF providers; and
- MTF Commanders"

Some of the categories mentioned, such as Non-network providers may have little or no contact with the contractor on a monthly basis. TOM Chapter 12 prohibits the contractor from conducting surveys, Section 3, 3.0. This may make the subject report statistically invalid based upon the scarcity of encounter data. Would the government consider changing this requirement to a quarterly report, which would give the contractor the benefit of the surveys used for the quarterly award fee board? If not, could the government please expound on the type of data fields they would like to see by these categories on a monthly basis?

RESPONSE: The requirement for a monthly report will not change. The Government will not define the data fields and expects the contractor to exercise a "best practice" approach to determining customer satisfaction as it delivers best value health care.

99. In Section B, claim volume quantities are provided for pricing each CLIN. Please provide your methodology for calculating the estimated quantities contained on this schedule for all periods of performance. Please also provide the estimated number of claims by month for each region during the first option period in order to provide an accounting of these claim volumes during the staggered transition schedule. Current volumes in all contracts are <u>much less</u> when both pharmacy and TFL volumes are extracted.

RESPONSE: Claims volumes are currently being revised and will be posted in an upcoming amendment. The volume projections, to be used for evaluation purposes only, were determined excluding TFL and pharmacy claims using regression analysis.

100. In Section B, claim volume quantities for electronic submissions are provided for pricing each CLIN. The RFP split between electronic and paper is 85/15. Actual experience in all contracts when pharmacy and TFL are extracted is about 20/80. Please provide your methodology for estimating the electronic claim volume. In addition, please provide the current percentage of network versus non-network providers as well as the associated claim volume for all existing MCS contracts.

RESPONSE: Consideration was given to the effect of requiring all network providers to submit claims electronically and that the HIPAA Transaction and Code rule will be in effect upon start of health care delivery. The current percentage of network

versus non-network providers and the associated claim volume for all existing MCS contracts can be determined from the data package.